

Nursing Documentation

Guideline: In ICFs/MR, information reflecting the nursing plan of care as well as other pertinent information should be documented in the individual's record in an accurate, timely, and legible manner.

DEFINITIONS:

Individual's record: A permanent legal document that provides a comprehensive account of information about the individual's health care status.

Primary care prescribers: Physicians, nurse practitioners, and physician's assistants who provide primary care services and are authorized to prescribe medications and treatments for people on their assigned caseloads.

RATIONALE:¹

1. Documentation in the individual's record facilitates communication among professionals from different disciplines and on different shifts. It provides information so that health care providers can deliver care in a coordinated manner.
2. Information in the individual's record is a source of data for quality assurance and peer review programs.
3. Reimbursement from third-party payers (i.e., Medicaid, Medicare) is based in part on the quality and timeliness of nursing care reflected in the individual's record.
4. The individual's record serves as a legal document that may be entered into courtroom proceedings as a record of care the person received.

EXPECTED OUTCOMES:

Nursing Assessment

Documentation should reflect that nursing assessment occurs on a timely and regular basis.

1. The admission assessment should be completed on the day of admission. Pertinent results of the assessment should be communicated to the primary care prescriber as warranted.
2. All aspects of the Physical Health section of the Single Plan should be completed prior to the annual team meeting.
3. A physical nursing assessment should be completed quarterly for those individuals who do not require a medical plan of care. A primary care prescriber's examination may be used as a quarterly assessment required for those individuals for which 24 hour nursing care has not been ordered.
4. Identified health problems should be reviewed on a regular and timely basis. Documentation should include the status of the identified problems until they are resolved. When the problem is resolved, it should be noted.
5. Normal and abnormal findings should be included in comprehensive assessment reports.

Diagnostic Reasoning

Documentation should reflect that the individual's health status evaluation is based on the information received and analyzed as a result of nursing assessment.

1. The health needs, strengths, and problems identified during nursing assessment should be part of the **Physical Health** section of the Single Plan.
2. The Single Plan should be updated to reflect changes in the health status of the person.

Planning

Documentation should reflect that a plan of care is developed based on nursing assessment and diagnostic reasoning.

1. Anticipated outcomes of nursing activities should be incorporated in the **Physical Health** section of the Single Plan.
2. Nursing interventions developed to address the person's health needs or problems will be included in the **Physical Health** section of the Single Plan.

Implementation

Documentation should reflect that the plan developed to meet health needs/problems is being implemented.

1. The nursing notes should reveal that treatment rendered is consistent with the nursing plan of care.
2. The nursing notes should include information about the status of the health situation or problem, the treatment rendered, and the person's response to treatment.
3. Medication Administration Records (MARs) should be completed at the time medications are given and treatments are completed.

Evaluation

Documentation should reflect that outcomes of nursing interventions are carefully evaluated.

1. The nursing notes should reflect the need to continue and/or change the plan of care.
2. The nursing notes should reflect changes in the nursing plan of care.
3. The nursing notes should include information about contacts with primary care prescribers and other members of the interdisciplinary team regarding the person's health status.

GENERAL GUIDELINES

When to Chart

1. Record nursing actions and individual responses as soon **after** they occur as possible.
2. Never document medications or treatments before they are given or completed.

What to Chart

1. *Symptoms*: Use the person's own words, communication gestures, or non-verbal cues as much as possible.
2. *Your observations*: Failure to document leaves gaps in the record that can be interpreted as neglect.
3. *All injuries, illnesses and unusual health situations* until they are resolved. There should be entries in the nursing notes on a regular basis until the problem is no longer present. When the problem is resolved, it should be documented.
4. *All contacts with the primary care prescriber*:
 - a. Document what information was relayed to the primary care prescriber.

- b. If the primary care prescriber sees or reviews an individual's specific health problem, document what occurred:
 - the chart was reviewed,
 - the individual was seen, or
 - if the individual was examined.
 - c. If the contact is made by phone, document what was discussed and results of the contact (e.g., no orders given, observe).
 - d. Document the plan for follow-up (e.g., to see the physician on morning rounds).
5. *Response to a medication or treatment:* This includes therapeutic effects as well as side effects.
6. *All appointments and consultations:*
 - a. Name of consultant and specialty
 - b. Reason for consultation
 - c. Brief report of findings if available--if not, say so. If the consultation report is filed in the chart, the nursing note may refer the reader to the consultation report.
 - d. If the consultation report is filed in the chart and it includes follow-up plans, the nursing note may refer the reader to the consultation report.
 - e. The person's response to appointment.
7. *New symptoms or conditions:* Each of the following should be documented in the nursing notes (or other designated documents) at the time of occurrence along with nursing action taken and the person's response:
 - a. abrasions, cuts, pressure marks
 - b. falls and bumps, with or without apparent injury
 - c. elevated temperature
 - d. pressure ulcers including description and treatment until resolved
 - e. rectal checks for constipation including findings and treatment
 - f. seizures with complete description and treatment, if any
 - g. possible adverse reactions to food or medicine
 - h. refusal of meals or medications
 - i. vomiting including type, amount, and treatment
 - j. STAT medications including time order is received and time medication is given
 - k. unusual behavior or condition of the individual
 - l. diarrhea or any change in bowel pattern
 - m. any significant increase or decrease in weight
 - n. changes or unusual difficulty in obtaining vital signs
8. *Routine, ongoing treatments or conditions:* (e.g., acne)
Document status at least once quarterly and more frequently as indicated.
9. *Any action you take in response to an individual's problem.*
10. As a general rule, **do not chart actions completed by others**. In some instances it is permissible to chart something done by someone else BUT your notation should identify the person who actually gave the care.

How to Chart

1. Date and time each entry.
2. Indicate both the time the entry is made into the record and the time the observation or activity took place.
3. All entries in the individual's record should be written or printed legibly in permanent black ink.
4. Do not leave blank lines between entries. Draw a line through unused spaces before and after your signature.
5. Use only abbreviations and symbols approved in agency policies.
6. All entries in the individual's record should be written objectively and without bias, personal opinion, or value judgment.
7. The use of slang, cliches, or labels should be avoided unless used in the context of a direct quote.
8. Interpretations of data should be supported by descriptions of specific observations.
9. Documentation should be clear, concise, and specific.
 - a. Don't use vague terms.
 - b. Generalizations such as "good", "fair", "moderate", and "normal" should be avoided.
 - c. Findings should be as descriptive as possible including specific information about the appearance or findings related to size, shape, and amount.
10. Correcting errors:
 - a. Draw **one straight line** through the incorrect entry,
 - b. Write "error" above it,
 - c. Initial and date the correction.
 - d. Never use white-out, erase, or obliterate an entry in the individual's record.
11. Late entries: If you forget to chart something, it may be entered into the record at a later time but you must clearly state the date and time the entry is being made and the date and time the care or observations actually occurred. The entry should begin with the words "Late entry".
12. All entries in the nursing notes should be signed. The signature should include the first initial, last name and title (e.g., S. Jones, RN).
13. A record of initials and signatures should be maintained according to facility policy so that the person using the initials and signatures used in documentation can be identified.

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SUPPORTING INFORMATION

Nursing Process

Assessment:

Assessment is the first step in the nursing process and involves systematic and deliberate collection of information to determine the person's current and past functional and health status. In addition, during the nursing assessment the nurse evaluates the person's present and past coping patterns. Information for the nursing assessment is obtained through interview with the person or appropriate family or staff member; physical examination; observation; review of records; and collaboration with other health professionals.

Diagnostic Reasoning:

Diagnostic reasoning is the second step in the nursing process and involves the analysis of information obtained during the assessment step and the evaluation of the person's health status based on that information.

Planning:

Planning is the third step in the nursing process and involves setting priorities, developing desired outcomes to problems/needs, and designing nursing interventions.

Implementation:

Implementation is the fourth step in the nursing process and involves preparation, intervention, and documentation.

Evaluation:

Evaluation is the fifth step in the nursing process. In this step the nurse determines the person's progress toward meeting health goals, the value of the nursing plan of care in achieving those goals, and the overall quality of care received by the person. There are several conclusions which may be drawn and actions which may result from the evaluation step.

Conclusion

1. Problem resolved
2. Potential problem prevented;
risk factors remain
3. Possible problem ruled out
4. Actual problem still exists
5. Problem is reduced
6. All problems resolved;
no new problems

Action

1. Remove from active problem list.
2. Maintain on the active problem list.
3. Remove from active problem list.
4. Maintain on active problem list; care
plan may need revision or the same plan
may be continued and allow more time
for response to treatment.
5. Maintain on the active problem list; care
plan may need revision or the same plan
may be continued and allow for more
time for response to treatment.
6. No further nursing plan of care is
needed.

REFERENCE

1. Scott, R.W. (2006). Legal Aspects of Documenting Patient Care for Rehabilitation Professionals (3rd ed.). Sudbury, MA: Jones and Bartlett Publishers.